



Estimates for the Insurance Coverage Provisions of the Affordable Care Act Updated for the Recent Supreme Court Decision

The Congressional Budget Office (CBO) and the staff of the Joint Committee on Taxation (JCT) have updated their estimates of the budgetary effects of the health insurance coverage provisions of the Affordable Care Act (ACA) to take into account the Supreme Court decision issued on June 28, 2012.¹ This report describes those new estimates, how they were derived, and how they differ from the previous ones.

The insurance coverage provisions of the ACA establish a requirement for most legal residents of the United States to obtain health insurance or pay a penalty tax; create insurance “exchanges” through which certain individuals and families may receive federal subsidies to substantially reduce their cost of purchasing health insurance; significantly expand eligibility for Medicaid—now at each state’s option; impose an excise tax on certain health insurance plans with relatively high premiums; establish penalties on certain employers who do not provide minimum health benefits to their employees; and make other changes to prior law.²

The Supreme Court’s decision has the effect of allowing states to choose whether or not to expand eligibility for coverage under their Medicaid program pursuant to the ACA. Under that law as enacted but prior to the Court’s ruling, the Medicaid expansion appeared to be mandatory for states that wanted to continue receiving federal matching funds for any part of their Medicaid program.³ Hence, CBO and JCT’s previous estimates reflected the expectation that every state would expand

¹ See *National Federation of Independent Business v. Sebelius*, 132 S. Ct. 2566 (2012). The ACA comprises the Patient Protection and Affordable Care Act (Public Law 111-148) and the health care provisions of the Health Care and Education Reconciliation Act of 2010 (P.L. 111-152). As used here, the term “ACA” includes the effects of subsequent related changes in statute.

² For more information on the insurance coverage provisions of the ACA, see the statement of Douglas W. Elmendorf, Director, Congressional Budget Office, before the Subcommittee on Health, House Committee on Energy and Commerce, *CBO’s Analysis of the Major Health Care Legislation Enacted in March 2010* (March 30, 2011) .

³ CBO and JCT’s previous estimate of the effects on insurance coverage of the ACA, before the Court’s decision, were reflected in the projections contained in Congressional Budget Office, *Updated Budget Projections: Fiscal Years 2012 to 2022* (March 2012) and further described in Congressional Budget Office, *Updated Estimates for the Insurance Coverage Provisions of the Affordable Care Act* (March 2012).

eligibility for coverage under its Medicaid program as specified in the ACA. As a result of the Court's decision, CBO and JCT now anticipate that some states will not expand their programs at all or will not expand coverage to the full extent authorized by the ACA. CBO and JCT also expect that some states will eventually undertake expansions but will not do so by 2014 as specified in the ACA.

CBO and JCT now estimate that the insurance coverage provisions of the ACA will have a net cost of \$1,168 billion over the 2012–2022 period—compared with \$1,252 billion projected in March 2012 for that 11-year period—for a net reduction of \$84 billion. (Those figures do not include the budgetary impact of other provisions of the ACA, which in the aggregate reduce budget deficits.)⁴ The projected net savings to the federal government resulting from the Supreme Court's decision arise because the reductions in spending from lower Medicaid enrollment are expected to more than offset the increase in costs from greater participation in the exchanges. That outcome is projected to occur despite the fact that the government's average additional costs per person in the exchanges will be greater than its average savings per person for those who, as a result of the Court's ruling, will not enroll in Medicaid. Why? Because the number of additional people entering the exchanges as a result of the ruling is projected to be only about half the number who will not be obtaining Medicaid coverage, many of whom will be ineligible to participate in the exchanges.

In updating their estimates, CBO and JCT have not relied on state-by-state predictions about Medicaid expansions under the ACA. Instead, they have projected the approximate shares of the affected population residing in states that will fall into different broad categories—ranging from no expansion to an expansion encompassing the income threshold established by the ACA. States will face different costs and benefits from expanding their Medicaid programs and will have different preferences about whether or to what degree to do so. Those that opt to expand their programs may also have different preferences with regard to timing; some may want to expand eligibility in 2014, while others may prefer to delay expansion until later in the decade. Moreover, how flexible executive branch agencies will be regarding the choices that states will have—particularly states' options for pursuing partial expansions—is unclear. Hence, what states will be able to do and what they will decide to do are both highly uncertain. As a result, CBO and JCT's estimates reflect an assessment of the probabilities of different outcomes (without any explicit prediction of which states make which choices) and are, in their judgment, in the middle of the distribution of possible outcomes. Future legal or administrative actions will certainly affect those outcomes; CBO and JCT's assessments in this analysis should not be viewed as representing a single definitive interpretation of how the ACA should or will be implemented in light of the Court's decision.

⁴ See the statement of Douglas W. Elmendorf, Director, Congressional Budget Office, before the Subcommittee on Health, House Committee on Energy and Commerce, *CBO's Analysis of the Major Health Care Legislation Enacted in March 2010* (March 30, 2011). For the provisions of the ACA unrelated to insurance coverage, most of which involve ongoing programs or revenue streams, separating the portion of projected spending for those programs or revenue streams that is attributable to the ACA from the portion that would have existed under prior law is very difficult.

In its decision, the Supreme Court upheld the constitutionality of the ACA's provision requiring most individuals to obtain insurance coverage or pay a penalty tax.⁵ The Court viewed that arrangement as a valid exercise of the Congress's constitutional power to levy taxes. That ruling has not caused CBO and JCT to change their estimate of the impact of the coverage requirement and the associated penalty on people's decisions about whether to obtain insurance coverage. CBO and JCT's original assessment of the effects of the coverage requirement was strongly rooted in comparisons with other taxes and penalties, drawing heavily from the academic literature on tax compliance. In earlier estimates, CBO and JCT expected that individuals would perceive the mandate as a requirement to purchase insurance or pay a penalty tax administered by the Internal Revenue Service. Because the Court upheld the constitutionality of that arrangement, CBO and JCT continue to expect similar behavioral responses to the insurance requirement.

Changes in the Estimated Effects of the ACA on Insurance Coverage and the Federal Budget

In this update of figures published in March 2012, CBO and JCT now estimate that fewer people will be covered by the Medicaid program, more people will obtain health insurance through the newly established exchanges, and more people will be uninsured. The magnitude of those changes varies from year to year. In 2022, for example, Medicaid and the Children's Health Insurance Program (CHIP) are expected to cover about 6 million fewer people than previously estimated, about 3 million more people will be enrolled in exchanges, and about 3 million more people will be uninsured (see Table 1, at the end of this report).⁶ Although the estimates discussed here are dominated by the movements of people losing eligibility for Medicaid, other smaller shifts in coverage are expected to occur as well. The changes in coverage shown in Table 1 reflect the net effect of all estimated changes stemming from the Court's decision, not just the movements of people who lose eligibility for Medicaid. For example, relative

⁵ The ACA requires nearly every resident of the United States to obtain health insurance by January 1, 2014. People who do not comply with the individual coverage requirement will be charged a penalty, assessed through the Internal Revenue Code, although exemptions from that requirement or its associated penalties are provided for several categories of people—including those with taxable income below the threshold for mandatory tax filing (projected by CBO and JCT to be about \$10,000 for a single filer and about \$19,000 for a married couple in 2016), unauthorized immigrants, members of certain religious groups, people who would have to pay more than 8 percent of their income for health insurance, and those who obtain a hardship waiver. In 2016, the penalty for noncompliance with the requirement for obtaining insurance is set to be the greater of a flat dollar amount specified in statute (\$695 per individual and up to three times that amount for a family) or a percentage of income in excess of the filing threshold (2.5 percent of income).

⁶ The effect of the Court's decision is primarily to shift enrollment between Medicaid and exchanges or between participating in Medicaid and being uninsured. In addition, CBO estimates some changes in enrollment in the Children's Health Insurance Program. The changes in CHIP are very small compared with prior estimates in some years and are negligible in years, starting in 2016, when CHIP funding will be subject to a much lower ceiling. In general, in the tables accompanying this report, Medicaid and CHIP are combined, but in discussing the effect of the Court's decision, the focus is on Medicaid.

to prior estimates, not all of the increases in enrollment in exchanges and in the uninsured are among people who would have been newly eligible for Medicaid.

As a result of those changes in projected health insurance coverage, CBO and JCT now anticipate that the net costs of the coverage provisions of the ACA will be \$84 billion less over the 2012–2022 period than they estimated in March 2012 (see Table 2, at the end of this report). That reduction occurs mostly because federal spending during that period for Medicaid and CHIP is now projected to be \$289 billion less than previously expected, whereas the estimated costs of tax credits and other subsidies for the purchase of health insurance through the exchanges (and related spending) have risen by \$210 billion. Small changes in other components of the budget estimates account for the remaining \$5 billion of the difference.

Why are the projected Medicaid and CHIP savings stemming from the Supreme Court’s decision greater than the projected additional costs of subsidies provided through the exchanges? The key factors leading to that result are as follows:

- Only a portion of the people who will not be eligible for Medicaid as a result of the Court’s decision will be eligible for subsidies through the exchanges. According to CBO and JCT’s estimates, roughly two-thirds of the people previously estimated to become eligible for Medicaid as a result of the ACA will have income too low to qualify for exchange subsidies, and roughly one-third will have income high enough to be eligible for exchange subsidies. In addition, those who become eligible for subsidies will have to pay a portion of the exchange premium themselves, which will affect their decisions about whether to enroll in the exchanges.
- For the average person who does not enroll in Medicaid as a result of the Court’s decision and becomes uninsured, federal spending will decline by roughly an estimated \$6,000 in 2022.⁷
- For the average person who does not enroll in Medicaid as a result of the Court’s decision and enrolls in an exchange instead, estimated federal spending will rise by roughly \$3,000 in 2022—the difference between estimated additional exchange subsidies of about \$9,000 and estimated Medicaid savings of roughly \$6,000.⁸
- With about 6 million fewer people being covered by Medicaid but only about 3 million more people receiving subsidies through the exchanges and about 3 million more people being uninsured, and because the average savings for each person who becomes uninsured are greater than the average additional costs for each person who receives exchange subsidies,

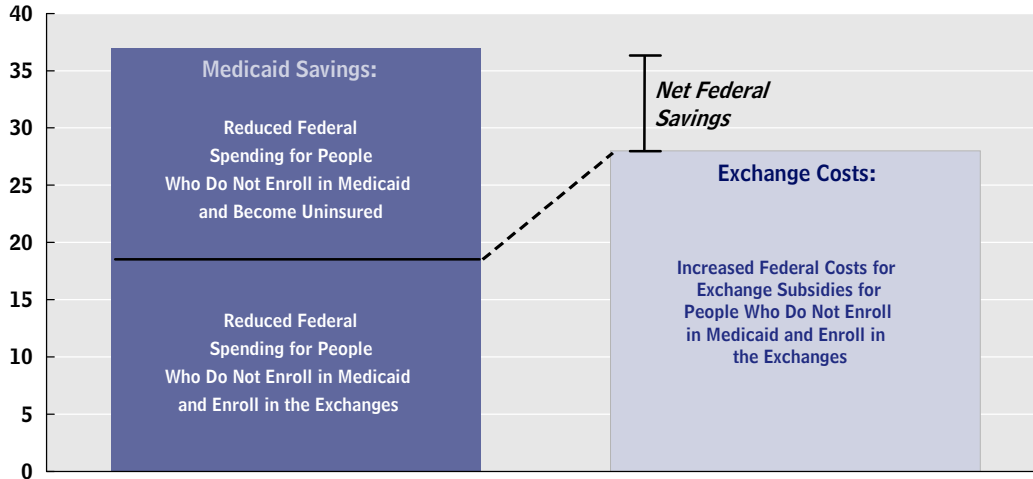
⁷ That amount equals the change in Medicaid and CHIP spending for that year divided by the change in enrollment in the programs; in 2022, spending for Medicaid and CHIP is estimated to be reduced by \$37 billion and enrollment is expected to be reduced by 6 million people.

⁸ The estimated additional exchange subsidies equal the change in exchange subsidies for that year divided by the change in enrollment in the exchanges; in 2022, exchange subsidies are estimated to increase by \$28 billion and enrollment is expected to increase by 3 million people.

Figure 1.

Major Effects on the Federal Budget in 2022 of Changes in Medicaid Enrollment Due to the Recent Supreme Court Decision

(Billions of dollars)



Sources: Congressional Budget Office and the staff of the Joint Committee on Taxation.

Notes: The effects shown in the figure reflect the major changes in enrollment and do not include smaller shifts in coverage. For example, relative to prior estimates, not all of the increases in enrollment in exchanges and in the uninsured are among people who would have been newly eligible for Medicaid.

See the Supreme Court's opinion issued on June 28, 2012 (*National Federation of Independent Business v. Sebelius*, 132 S. Ct. 2566 [2012]).

the projected decrease in total federal spending on Medicaid is larger than the anticipated increase in total exchange subsidies (see Figure 1).

Updated Estimates of the Budgetary Effects of the Insurance Coverage Provisions of the ACA

CBO and JCT now estimate that the insurance coverage provisions of the ACA will have a net cost of \$1,168 billion over the 2012–2022 period—compared with \$1,252 billion projected in March 2012 for that 11-year period (see Table 2).⁹

That net cost reflects the following:

- Gross costs of \$1,683 billion for Medicaid, CHIP, tax credits, and other subsidies for the purchase of health insurance through the newly

⁹ The budgetary effects of the ACA discussed in this report are the effects of the coverage provisions on federal revenues and mandatory spending; they do not include federal discretionary administrative costs, which will be subject to future appropriation action. CBO has previously estimated that the Internal Revenue Service will need to spend between \$5 billion and \$10 billion over 10 years to implement the law and that the Department of Health and Human Services and other federal agencies will have to spend at least \$5 billion to \$10 billion to implement the law over that period. In addition, the ACA included explicit authorizations for spending on a variety of grant and other programs; that funding is also subject to future appropriation action.

established exchanges (and related costs), and tax credits for small employers. Those gross costs include spending of \$642 billion for Medicaid and CHIP (\$289 billion less than the March 2012 projections), and \$1,017 billion for exchange subsidies (\$210 billion more than the March 2012 projections). Gross costs are \$79 billion less than what was estimated in March 2012.

- Those gross costs are offset in part by \$515 billion in receipts from penalty payments, the new excise tax on high-premium insurance plans, and other budgetary effects (mostly increases in tax revenues stemming from changes in employer-provided insurance coverage). That offsetting amount is \$5 billion more than what was estimated in March 2012.¹⁰

Those amounts do not encompass all of the budgetary impacts of the ACA because that legislation has many other provisions, including some that will cause significant reductions in Medicare spending and others that will generate added tax revenues, relative to what would have occurred under prior law. CBO and JCT have not updated their estimate of the overall budgetary impact of the ACA; previously, they estimated that the law would, on net, reduce budget deficits.

CBO and JCT have, however, updated their estimate of the budgetary impact of repealing the ACA, incorporating the updated estimates of the effects of the coverage provisions presented here.¹¹ (For various reasons, the estimated budgetary effects of repealing the ACA are not equivalent to an estimate of the budgetary effects of the ACA with the signs reversed.) On net, CBO and JCT estimate, repealing the ACA would increase federal budget deficits by \$109 billion over the 2013–2022 period. Repealing the coverage provisions discussed in this report would save \$1,171 billion over that period, but repealing the rest of the act would increase direct spending and reduce revenues by a total of \$1,280 billion.¹²

Medicaid Expansion After the Supreme Court's Decision

Before the Supreme Court's decision, states appeared to have been required to extend Medicaid coverage, beginning in 2014, to all individuals whose income is below 138 percent of the federal poverty level (FPL) or lose federal matching

¹⁰ States' spending for Medicaid and CHIP will also be affected by the Court's decision. CBO estimates that states' spending related to the coverage provisions of the ACA will total roughly \$41 billion over the 2012–2022 period, compared with the roughly \$73 billion estimated in March 2012.

¹¹ See Congressional Budget Office, [letter to the Honorable John Boehner providing an estimate for H.R. 6079, the Repeal of Obamacare Act](#) (July 2012).

¹² The estimated effects of *repealing* the coverage provisions of the ACA differ slightly from CBO and JCT's current projections of the budgetary effects of those provisions. Some of the effects of changes made under the ACA that are captured in those current projections are expected to continue even if the law is repealed. In addition, the projections for the effects of the coverage provisions presented in this document include small effects in fiscal year 2012, but an estimate of repeal includes effects only for 2013 through 2022 because of the assumption that repeal would be enacted near the start of fiscal year 2013.

funds for their existing Medicaid program.¹³ Thus, it was expected that, under the ACA, individuals with income below 138 percent of the FPL (and who met the other requirements of the law) would be eligible for Medicaid in every state beginning in 2014. The Court's decision has the effect of converting the ACA's Medicaid coverage expansion from a de facto requirement for states to an option for them.

Eligibility for Federal Health Care Programs Under the ACA

Currently, Medicaid and CHIP cover most children and some parents of dependent children whose family income is below 138 percent of the FPL—although the income ceilings for parents vary widely among states. Until the new eligibility criteria established by the ACA go into effect in 2014, most childless adults will not be eligible for Medicaid, except in cases in which states have obtained waivers of federal law. Therefore, most of the new enrollment projected to occur under the ACA's Medicaid expansion is expected to be among childless adults and parents who are not already covered under their state's eligibility rules.

Under the ACA, the federal government will fully cover the cost of the newly eligible individuals in 2014, 2015, and 2016. After that, states will be required to contribute toward the costs for those individuals. States' shares of the costs rise over several years so that, for 2020 and subsequent years, states will be required to pay 10 percent of the costs for such individuals. For any new enrollees who were previously eligible for Medicaid, traditional federal matching rules will apply; on average, the federal government pays about 57 percent of Medicaid costs, and states pay the rest (although the shares vary by state).

Under the ACA, states are required to maintain coverage up to the income eligibility levels they had established under prior law for children until 2019 and for adults until 2014. That "maintenance of effort" requirement and the requirement that states determine eligibility using the measure of modified adjusted gross income (MAGI) specified in the ACA were not directly affected by the Court's decision.

In addition to expanding Medicaid coverage, the ACA provides for subsidies to certain individuals and families who purchase insurance through the exchanges established under the law.¹⁴ To be eligible for subsidies, individuals and families must have income between 100 percent and 400 percent of the FPL and cannot have access to an affordable offer of insurance from an employer or be eligible for Medicaid (among other criteria). In 2014, eligible individuals or families with income between 100 percent and 133 percent of the FPL will be able to enroll in the reference plan in an exchange by paying 2 percent of their income; individuals and families with more income will have to pay a higher percentage of their

¹³ The FPL for a family of four, for example, is projected to be about \$24,000 in 2014. The legislation established the eligibility threshold for Medicaid at 133 percent of the FPL, but five percent of applicants' income is disregarded, raising the effective threshold to 138 percent of the FPL.

¹⁴ CBO and JCT expect that subsidies will be available to people in exchanges run entirely by states, exchanges run entirely by the federal government, and exchanges run together by states and the federal government.

income according to a schedule established in the ACA.¹⁵ For example, CBO and JCT estimate that eligible individuals or families with income equal to 100 percent of the FPL in 2014 (roughly \$24,000 for a family of four) will pay about \$480 toward their premium for the reference plan. Eligible individuals or families with income at 150 percent of the FPL in 2014 will be able to enroll in such coverage by paying 4 percent of their income.¹⁶ Such individuals and families, because they have income at or below 150 percent of the FPL, will also be eligible for cost-sharing subsidies in the exchanges, whereby their insurance coverage will pay, on average, 94 percent of their covered medical expenses. In contrast, most state Medicaid programs either do not require any payment to enroll or charge only small monthly premiums and have only small cost-sharing amounts for medical services.

If a state decides not to expand its Medicaid program to the extent authorized under the ACA, some people who would not be eligible for Medicaid will instead be eligible for premium and cost-sharing subsidies in the insurance exchanges. In particular, individuals with income between 100 percent and 138 percent of the FPL who live in a state that chooses not to expand Medicaid coverage or to defer such an expansion and who meet certain other criteria would be eligible for such subsidies.

Key Factors in States' Decisions Regarding Medicaid Expansion

In the wake of the Supreme Court's decision, there are many questions about how the new state option for Medicaid will be administered. For example, final regulatory guidance is not yet available regarding whether states will be allowed to begin their expansion after 2014, to expand eligibility to a threshold below 138 percent of the FPL, or to cover only certain groups of people. Under other provisions of Medicaid law that specify options for states, they may cover "reasonable categories" of individuals with income below a specified threshold. Whether the Court's decision allows for that flexibility, or whether the current Administration or future ones will allow such flexibility, will have a significant impact on the choices that state governments make.

CBO and JCT's updated estimates reflect careful consideration of the many factors that state officials are likely to take into account in determining if, when,

¹⁵ Whereas the ACA included a provision to disregard 5 percent of income for determining eligibility for Medicaid, no such provision exists for determining subsidies in the exchanges. The reference plan is the "silver" plan in the exchange with the second-lowest premium for an individual's age group (for single coverage) or with the second-lowest premium among family plans (for family coverage). A silver plan has an actuarial value of 70 percent; that value is the average share of costs for covered benefits that will be paid by the plan. The other 30 percent represents amounts that enrollees will pay, on average, for covered medical services in the form of deductibles or other cost sharing.

¹⁶ Under the ACA, the percentage of income that individuals or families pay toward their premiums is indexed over time; its future value depends on changes in wages and health insurance premiums. For additional information on indexing premiums under the ACA, see Congressional Budget Office, *Additional Information About CBO's Baseline Projections of Federal Subsidies for Health Insurance Provided Through Exchanges* (May 2011).

and to what extent Medicaid coverage will be expanded. In making their decisions, states will face different incentives depending on their overall budgetary situation, their current thresholds for Medicaid eligibility, the amounts that they and their local governments spend to provide health care to uninsured people or to pay providers for uncompensated care, the number of people likely to enroll in the program after an expansion (including some of those already eligible but not enrolled), the federal contributions toward the cost of their care, and many other factors. Moreover, states often have different preferences regarding their policies even when facing the same incentives.

One significant incentive for states to undertake the Medicaid expansion prescribed in the ACA is that the federal government is scheduled to cover a very large share of the costs of that expansion. Specifically, for people who become newly eligible for Medicaid under the expansion, the federal government will cover 100 percent of those costs from 2014 through 2016 and a share declining to 90 percent of the costs in 2020 and thereafter. Thus, states will be able to offer a significant benefit to some of their residents while bearing only a small fraction of the costs. In addition, states and local governments will probably realize savings in existing programs that provide direct care to people who are uninsured or that cover uncompensated costs incurred by providers serving uninsured residents. Pressure to expand Medicaid coverage is also likely to come from health care providers that stand to gain when more people have coverage. In particular, hospitals that will receive smaller disproportionate share payments from Medicaid under the ACA may exert pressure on states to make up for those losses by expanding Medicaid eligibility.¹⁷

At the same time, there are significant disincentives for states to expand Medicaid eligibility. One is that states would ultimately have to bear some costs for an expansion of Medicaid coverage during a period when their budgets are already under pressure, in part from the rising costs of the existing Medicaid program. Health care costs tend to rise faster than those for other services or products in the economy. And although the 10 percent share of the costs of newly eligible people that states would ultimately bear would be a small share of total additional Medicaid spending, it would nevertheless represent a large extra cost for some states. In addition, CBO estimates, and states expect, that expanding the Medicaid-eligible population would lead to an increase in enrollment among those who would have been eligible under prior law and would not qualify for the higher federal matching rates, resulting in additional costs for participating states. States may also fear that the federal government, which faces its own severe budgetary pressures, will ultimately reduce the federal matching rate and that if it did so, rolling back expansions already in place would be difficult.

States' choices will also be significantly shaped by how the current Administration and future ones respond to the Supreme Court's decision. CBO

¹⁷ States make disproportionate share (DSH) payments to certain hospitals serving large numbers of Medicaid and low-income patients relative to other hospitals. The ACA reduced the amounts of DSH payments that states may make beginning in 2014. CBO expects that the Court's decision will not affect those cuts, which are estimated to total more than \$22 billion over the 2014–2022 period.

anticipates that, instead of choosing to expand Medicaid eligibility fully to 138 percent of the FPL or to continue the status quo, many states will try to work out arrangements with the Department of Health and Human Services (HHS) to undertake partial expansions. For example, some states will probably seek to implement a partial expansion of Medicaid eligibility to 100 percent of the FPL, because, under the ACA, people below that threshold will not be eligible for subsidies in the insurance exchanges while people above that threshold will be if they do not have an offer of affordable coverage from an employer and meet other eligibility requirements. Other states may seek to expand coverage to levels above their existing thresholds but below 100 percent of the FPL. In addition, some states may pursue a range of other options that would have the effect of reducing participation in Medicaid compared with earlier estimates. For example, states might seek changes to methodologies and procedures for determining eligibility. How the current Administration and future ones will respond to states' interest in pursuing these various approaches is unclear.

The timing for expanding Medicaid eligibility may be another choice for states. Some states may want to delay their Medicaid expansion by a year or more, until budgetary pressures stemming from the recent recession and slow economic recovery abate somewhat. Other state governments may take some time to weigh the various options. In contrast, states that are in better fiscal condition or that anticipate relatively small additional costs or potential savings from a Medicaid expansion (because of anticipated reductions in their costs for uncompensated care or other state-funded health care), are less likely to want to defer implementation. However, how much flexibility states will have in setting the timing of an expansion is unclear.

Given those various considerations, states' decisions will probably span a very wide range: Some states will probably forgo the expansion entirely; some are likely to expand coverage to everyone whose income is below 138 percent of the FPL; and if the flexibility is allowed, some states may choose partial expansions. Further, states may be able to make those choices in any year after 2014. The updated estimates by CBO and JCT represent their assessment of the middle of the distribution of the many possible outcomes arising from the Supreme Court's decision. The estimates do not reflect a forecast of specific decisions by individual states; many different combinations of state decisions could produce the projected results. Future legal or administrative actions will probably change the scope of what is possible under the ACA and the Court's decision; CBO and JCT's assessments should not be viewed as representing a single definitive interpretation of those possible outcomes.

Projected Decisions by States Regarding Expanding Medicaid

CBO and JCT project that under the ACA after the Court's decision, of the people who would become newly eligible for Medicaid if *all* states opted to expand coverage up to 138 percent of the FPL, about two-thirds will become eligible for Medicaid by 2022 and about one-third will not. Those who will become eligible reside in states that will opt to partially or fully expand coverage. Because some states are likely to delay expanding Medicaid coverage until after 2014, the projected proportion that will become eligible is smaller in earlier years.

For this estimate, CBO and JCT considered states' possible behavior relating to three types of choices: whether or not eligibility for Medicaid will be expanded, how far any eligibility expansions will extend, and when any such expansions will occur. For 2022, CBO and JCT project these results:

- About one-third of the potential newly eligible population will reside in states that choose to fully extend coverage up to 138 percent of the FPL. The costs to the federal government for those people will not be affected by the Supreme Court's decision.
- About one-half of the potential newly eligible population will reside in states that partially extend Medicaid coverage to an income threshold less than 138 percent of the FPL. For this analysis, CBO and JCT adopted an assumption that 40 percent would be in states that extend coverage to 100 percent of the FPL and 10 percent in states that extend to a lower percentage; as with other values underlying the analysis, those shares were designed to represent the middle of a range of possible outcomes.
 - In all of those states, people with income between 100 percent and 138 percent of the FPL will be eligible for exchange subsidies if they do not have access to an offer of affordable health insurance from their employer and meet other eligibility requirements. On average, those exchange subsidies will be more costly to the federal government than Medicaid coverage for those people would have been; however, fewer of those people will take up exchange coverage than would have enrolled in Medicaid because of the higher out-of-pocket costs in the exchanges.
 - In states that expand coverage up to a limit less than 100 percent of the FPL, some people with income above that limit but below the FPL will not be eligible for either Medicaid or exchange subsidies and will generally be uninsured. For those people, the government will not bear any Medicaid or exchange costs.
- The remainder, about one-sixth, will reside in states that do not extend Medicaid coverage at all in the next decade. As with people who reside in states that partially expand coverage, most people in those states who have income between 100 percent and 138 percent of the FPL and meet other eligibility requirements will be eligible for subsidies through exchanges; the others, with income below 100 percent of the FPL, will not be eligible for either Medicaid or exchange subsidies.
- In addition to the impact on the coverage of the potential newly eligible population, CBO and JCT estimate that the Court's decision will also affect the coverage of people who, in the absence of the ACA, would have been eligible for Medicaid and CHIP but would not have enrolled. Some of those people will be induced to enroll because of the ACA's requirement to obtain health insurance and because of publicity related to the expansions of Medicaid coverage. However, as a result of some states

choosing not to extend eligibility levels or choosing to extend coverage levels to an income limit less than 138 percent of the FPL, those spillover effects on the population that would have been eligible in the absence of the ACA will be reduced. CBO and JCT estimate that about one-fifth of the people who would have been eligible for Medicaid in the absence of the ACA and were, in prior estimates, projected to enroll will no longer enroll in Medicaid or CHIP.

CBO and JCT project that the coverage expansions will unfold according to the following rough timetable:

- About one-third of the people who will ultimately become newly eligible for Medicaid reside in states that will expand their program beginning in 2014.
- About one-third of newly eligible people will reside in states that will delay their coverage expansion until 2015.
- The remaining one-third will reside in states that will delay longer than one year—expanding coverage in 2016, 2017, or 2018.

CBO and JCT project that the newly eligible people living in states more likely to expand coverage to 138 percent of the FPL are also more likely to see the expansion begin in 2014, while those newly eligible people living in states that are more likely to choose lower income eligibility thresholds or other options to limit their costs are more likely to see expansion occurring later.

Insurance Coverage After the Supreme Court's Decision

Compared with CBO and JCT's March 2012 estimate, the changes stemming from the Supreme Court's decision result in fewer people now expected to obtain coverage from Medicaid or CHIP and more people now expected to obtain coverage through insurance exchanges and to be uninsured. For example, CBO and JCT now estimate that, relative to their March 2012 projections, 6 million fewer people will be newly enrolled in Medicaid and CHIP as a result of the ACA in 2014 and in 2022 (see Table 1). The relative drop in the estimated number of new enrollees is greater in the earlier years of the period—about 45 percent of those projected to be newly enrolled in 2014 in prior estimates compared with about 35 percent in 2022—because a significant number of people are expected to reside in states that will not expand Medicaid coverage immediately but will do so later in the decade.

By CBO and JCT's estimate, in 2014 there will be 2 million more enrollees in insurance exchanges and 4 million more uninsured than previously projected. In 2022, 3 million more people will be enrolled in the exchanges and 3 million additional people will be without any insurance. Some of those people are not those who previously were expected to enroll in Medicaid but would nevertheless be affected by the changes to Medicaid. Not all of those people would have been projected to be enrolled in Medicaid under prior estimates, in part because other

small changes will occur in the number of people with employment-based and nongroup insurance.

CBO and JCT now estimate that the ACA, in comparison with prior law before the enactment of the ACA, will reduce the number of nonelderly people without health insurance coverage by 14 million in 2014 and by 29 million or 30 million in the latter part of the coming decade, leaving 30 million nonelderly residents uninsured by the end of the period (see Table 3, at the end of this report). Before the Supreme Court's decision, the latter number had been 27 million.

The share of legal nonelderly residents with insurance is projected to rise from 82 percent in 2012 to 92 percent by 2022. According to the current estimates, from 2016 on, between 23 million and 25 million people will receive coverage through the exchanges, and 10 million to 11 million additional people will be enrolled in Medicaid and CHIP as a result of the ACA. Between 4 million and 6 million fewer people are estimated to have coverage through an employer, compared with coverage in the absence of the ACA. That number did not change significantly as a result of the Court's decision.

The changes in coverage in the wake of the Supreme Court's decision depend importantly on whether individuals who will no longer become eligible for Medicaid coverage instead become eligible for exchange subsidies and whether they enroll in coverage through those exchanges. By CBO and JCT's estimates:

- Of the 6 million people who will not have Medicaid coverage in 2022 as a result of the Court's decision:
 - About three-quarters would have been *newly eligible* for Medicaid under the ACA as estimated prior to the Supreme Court's decision, and
 - About one-quarter would have been *eligible for Medicaid or CHIP under pre-ACA rules* and, prior to the Court's decision, would have been expected to enroll in one of those programs—but, with fewer expansions of eligibility, will be less likely to become aware of and sign up for either program.¹⁸
- Among the people who would have been newly eligible for Medicaid under the ACA before the Court's decision, about one-third will have income between 100 percent and 138 percent of the FPL, and about two-thirds will have income below 100 percent of the FPL. Most people with income between 100 percent and 138 percent of the FPL in states that do not expand or defer expanding Medicaid will be eligible for subsidized coverage in the exchanges.

¹⁸ CBO and JCT do not expect the number of people enrolled in Medicaid or CHIP as the result of other provisions of the ACA to be affected by the Court's decision. In particular, the ACA provisions requiring states to maintain certain Medicaid and CHIP eligibility thresholds and procedures for adults through 2014 and for children through 2019 are expected to remain in effect.

- Some people who will now be eligible to purchase insurance through an exchange will find the insurance available through an exchange to be more attractive than Medicaid because of the better access it offers to certain providers of health care; other people will find an exchange to be less attractive than Medicaid because of higher out-of-pocket costs for premiums and cost sharing. On balance, CBO and JCT expect those higher costs to reduce enrollment in the exchanges relative to what it would have been in Medicaid.

The Supreme Court's decision upholding the constitutionality of the ACA's provision requiring most individuals to obtain insurance coverage or pay a penalty tax does not change CBO and JCT's assessment of the mandate's effect on coverage. Under the ACA, the consequence for not obtaining required coverage—the “shared responsibility payment”—is a penalty paid to the Treasury by taxpayers when they file their tax returns and enforced by the Internal Revenue Service. CBO and JCT's previous estimates of the mandate's impact on people's decisions to obtain insurance drew heavily from the literature on compliance with tax law.¹⁹ More generally, those estimates were based on an assessment of the strength of incentives—both financial and otherwise—to buy insurance. Financial considerations include the amount of any costs for premiums and cost sharing, as well as the penalty, if applicable, for not having insurance. Nonmonetary factors include the probability of detection, attitudes toward risk, enforcement procedures, awareness of the mandate, and social norms reflecting the prevalence of coverage.

The more limited Medicaid expansions that are projected to result from the Supreme Court's decision will probably lead to a gap in access to coverage for some people below the federal poverty level. As a result, CBO and JCT project an increase in the number of people who will be eligible for hardship exemptions, which will slightly reduce the prevalence of coverage and thus the strength of the social norm to obtain insurance. Changes in insurance coverage resulting from those effects are reflected in this estimate.

The Budgetary Effects of the ACA's Insurance Coverage Provisions After the Supreme Court's Decision

The largest changes in CBO and JCT's estimates of the budgetary effects of the coverage provisions of the ACA after the Supreme Court's decision are in the estimated costs of Medicaid and CHIP and of exchange subsidies and related spending.

Medicaid and CHIP Outlays

According to CBO and JCT's projections for the 2012–2022 period, spending for Medicaid resulting from the coverage provisions of the ACA will be \$288 billion less than the amounts estimated prior to the Supreme Court's decision, and such

¹⁹ See David Auerbach and others, *Will Health Insurance Mandates Increase Coverage? Synthesizing Perspectives from Health, Tax, and Behavioral Economics*, Congressional Budget Office Working Paper 2010-05 (August 2012).

spending for CHIP will be about \$1 billion less (see Table 2). About 6 million fewer people (mostly adults) are now projected to be enrolled in those programs, on average, over the 2014–2022 period. The reduction in Medicaid spending is expected to be \$37 billion in 2022, and the reduction in enrollment is expected to be 6 million in that year. The decline in projected Medicaid coverage reduces estimated federal spending by about \$6,000 per person in 2022, on average.²⁰

Exchange Subsidies and Related Spending

According to CBO and JCT's updated estimates, the subsidies to be provided through the insurance exchanges over the 2012–2022 period are \$210 billion higher than the previous estimates—\$178 billion more in projected tax credits for health insurance premiums and \$31 billion more in projected cost-sharing subsidies and related spending.²¹ As a result of the reduced availability of Medicaid, a significant number of people with income between 100 percent and 138 percent of the FPL are expected to be eligible for and to obtain insurance offered through the exchanges.

The average subsidy for the additional enrollees resulting from the Supreme Court's decision is expected to be higher than the average subsidy for all exchange enrollees for two reasons:

- The additional enrollees will have lower average income than those previously expected to purchase insurance through the exchanges, so they will qualify for higher federal subsidies for premiums and cost sharing.
- The additional enrollees are likely to spend more on health care, on average, than those previously expected to purchase insurance through the exchanges because people with lower income generally have somewhat poorer health. As a result, CBO and JCT now estimate that the premiums for health insurance offered through the exchanges, along with premiums in the individual market, will be 2 percent higher than those estimated in March 2012.²²

²⁰ That average cost per person who does not enroll in Medicaid does not reflect the cost of medical services only, as is the case for the per capita Medicaid costs that CBO typically reports. Rather, the figure presented here reflects both the medical costs of the enrollees and the effects of changes to state administrative and policy choices that result from the Court's decision.

²¹ The higher projected costs for exchange subsidies increase the probability that a provision of the ACA limiting reductions in the year-to-year indexing of exchange subsidies if those subsidies exceed a specified share of GDP will be triggered. The estimates reported here incorporate that greater probability. Related spending refers to spending for high-risk pools, premium review activities, loans to co-op plans, grants to states for the establishment of exchanges, and the net budgetary effects of proposed collections and payments for risk adjustments and transitional reinsurance. Taken together, those items are changed by a negligible amount by the Court's decision.

²² Under rules established by the ACA, in the market for individual coverage, insurers may not vary premiums on the basis of health status, regardless of whether a policy is offered through an exchange or directly to an individual. Projected premiums for insurance offered by large and small employers are essentially unchanged from CBO and JCT's March 2012 estimates.

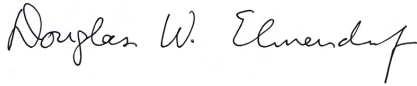
With those factors taken into account, the federal costs for each additional person enrolling in the exchanges (most of whom would have enrolled in Medicaid under CBO and JCT's prior estimate) will be approximately \$9,000 in 2022, on average. That amount is calculated by dividing the total increase in federal spending in the exchanges in 2022 (\$28 billion) by the number of additional enrollees (3 million people). The extra exchange costs per person are larger than the decrease in Medicaid costs per person primarily because, in CBO's and JCT's estimation, private health insurance plans in the exchanges will pay providers at higher rates than Medicaid pays and will have higher administrative costs than Medicaid, although there are other, partially offsetting, factors as well.

Other Revenues

According to the updated estimates, the amount of deficit reduction from penalty payments and other effects on tax revenues under the ACA will be \$5 billion more than previously estimated. That change primarily reflects a \$4 billion increase in collections from such payments by employers, a \$1 billion increase in such payments by individuals, and an increase of less than \$500 million in tax revenues stemming from a small reduction in employment-based coverage, which will lead to a larger share of total compensation taking the form of taxable wages and salaries and a smaller share taking the form of nontaxable health benefits.

Although the number of low-income people without health insurance is expected to increase by 3 million, on average, relative to the March 2012 estimates, CBO and JCT project only a slight increase, on net, in collections from penalty payments arising from the individual coverage requirement over the coming decade. The change in collections is modest for three reasons. First, many of the people who will not become eligible for Medicaid because of the Court's decision will have income that falls below the mandatory tax-filing threshold (projected by CBO and JCT to be about \$10,000 for a single filer and about \$19,000 for a married couple in 2016) and will therefore be exempt from penalties associated with the mandate. Second, the ACA exempts individuals who would have to pay more than 8 percent of their income for health insurance. Many people who will not become eligible for Medicaid or subsidies through exchanges because of the Court's decision will be eligible for that exemption. Third, people who will not be exempt under those criteria will probably receive a hardship exemption as provided in the ACA. It is likely that individuals who live in states that do not expand Medicaid eligibility up to 100 percent of the FPL, thereby leaving a gap between eligibility for Medicaid and eligibility for participation in the exchanges, will qualify for one of those exemptions.

This Congressional Budget Office (CBO) report was prepared in response to interest expressed by Members of Congress. In keeping with CBO's mandate to provide objective, impartial analysis, this report makes no recommendations. Jessica Banthin of CBO's Health, Retirement, and Long-Term Analysis Division and Holly Harvey and Jean Hearne of CBO's Budget Analysis Division prepared this report under the supervision of Linda Bilheimer and Pete Fontaine. The analysis described here was the work of many analysts at CBO and on the staff of the Joint Committee on Taxation; the CBO analysts who played especially important roles were Sarah Anders, James Baumgardner, Mark Hadley, Paul Jacobs, T.J. McGrath, Alexandra Minicozzi, Julia Mitchell, Kirstin Nelson, Lisa Ramirez-Branum, Robert Stewart, and Ellen Werble. The report is available on the agency's Web site (www.cbo.gov).



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Director



TABLE 1.
Comparison of Estimates of the Effects of the Insurance Coverage Provisions
Contained in the Affordable Care Act on Health Insurance Coverage

	March 2012 Baseline	July 2012 Estimate Incorporating Supreme Court Decision	Difference Between July 2012 and March 2012 Estimates
CHANGES IN INSURANCE COVERAGE			
(Millions of nonelderly people, by calendar year)			
2014			
Medicaid and CHIP	13	7	-6
Employer ^a	-2	-1	*
Nongroup and Other ^b	-1	-1	*
Exchanges	8	9	2
Uninsured ^c	-18	-14	4
2022			
Medicaid and CHIP	17	11	-6
Employer ^a	-3	-4	*
Nongroup and Other ^b	-3	-3	*
Exchanges	22	25	3
Uninsured ^c	-33	-30	3

Sources: Congressional Budget Office and the staff of the Joint Committee on Taxation.

Notes: The Affordable Care Act (ACA) comprises the Patient Protection and Affordable Care Act (P.L. 111-148) and the health care provisions of the Health Care and Education Reconciliation Act of 2010 (P.L. 111-152). As used here, the term "ACA" also includes the effects of subsequent related changes to statute. This estimate incorporates the effects of the Supreme Court's opinion issued on June 28, 2012 (*National Federation of Independent Business v. Sebelius*, 132 S. Ct. 2566 (2012)).

Numbers may not add up to totals because of rounding.

CHIP = Children's Health Insurance Program; * = between 0.5 million and -0.5 million.

- a. The change in employment-based coverage is the net result of increases in and losses of offers of health insurance from employers and changes in enrollment by workers and their families.
- b. Other includes Medicare; the effects of the ACA are almost entirely on nongroup coverage.
- c. The count of uninsured people includes unauthorized immigrants as well as people who are eligible for, but not enrolled in, Medicaid.

TABLE 2.

Comparison of Estimates of the Budgetary Effects of the Insurance Coverage Provisions Contained in the Affordable Care Act

	March 2012 Baseline	July 2012 Estimate Incorporating Supreme Court Decision	Difference Between July 2012 and March 2012 Estimates
11-YEAR EFFECTS ON THE FEDERAL DEFICIT, 2012-2022^{a,b}			
(Billions of dollars, by fiscal year)			
Medicaid and CHIP Outlays	931	642	-289
Exchange Subsidies and Related Spending ^c	808	1,017	210
Small Employer Tax Credits ^d	23	23	*
Gross Cost of Coverage Provisions	1,762	1,683	-79
Penalty Payments by Uninsured Individuals	-54	-55	-1
Penalty Payments by Employers ^d	-113	-117	-4
Excise Tax on High-Premium Insurance Plans ^d	-111	-111	*
Other Effects on Tax Revenues and Outlays ^e	-231	-231	*
Net Cost of Coverage Provisions	1,252	1,168	-84

Sources: Congressional Budget Office and the staff of the Joint Committee on Taxation.

Notes: The Affordable Care Act (ACA) comprises the Patient Protection and Affordable Care Act (P.L. 111-148) and the health care provisions of the Health Care and Education Reconciliation Act of 2010 (P.L. 111-152). As used here, the term "ACA" also includes the effects of subsequent related changes to statute. This estimate incorporates the effects of the Supreme Court's opinion issued on June 28, 2012 (*National Federation of Independent Business v. Sebelius*, 132 S. Ct. 2566 (2012)).

Numbers may not add up to totals because of rounding.

CHIP = Children's Health Insurance Program; * = between 0.5 billion and -0.5 billion.

- a. Does not include effects on the deficit of other provisions of the ACA not related to coverage, which in aggregate reduce deficits. It also does not include federal administrative costs that are subject to appropriation. CBO has previously estimated that the Internal Revenue Service will need to spend between \$5 billion and \$10 billion over 10 years to implement the ACA and that the Department of Health and Human Services and other federal agencies will have to spend at least \$5 billion to \$10 billion over that period. In addition, the ACA included explicit authorizations for spending on a variety of grant and other programs; that funding is also subject to future appropriation action.
- b. Positive numbers indicate increases in the deficit, and negative numbers indicate reductions in the deficit.
- c. Includes spending for high-risk pools, premium review activities, loans to co-op plans, grants to states for the establishment of exchanges, and the net budgetary effects of proposed collections and payments for risk adjustment and transitional reinsurance.
- d. The effects on the deficit of the ACA include the associated effects on tax revenues of changes in taxable compensation.
- e. The effects are almost entirely on tax revenues.

TABLE 3.
Estimate of the Effects of the Affordable Care Act on Health Insurance Coverage, Updated for Supreme Court Decision

EFFECTS ON INSURANCE COVERAGE^a		2012	2013	2014	2015	2016	2017	2018	2019	2020	2021	2022
(Millions of nonelderly people, by calendar year)												
Prior-Law Coverage ^b	Medicaid and CHIP	34	34	35	34	32	32	31	32	32	32	32
	Employer	154	156	157	157	159	160	160	161	161	160	161
	Nongroup and Other ^c	25	25	25	27	28	28	31	30	30	31	31
	Uninsured ^d	<u>55</u>	<u>56</u>	<u>56</u>	<u>56</u>	<u>56</u>	<u>57</u>	<u>58</u>	<u>57</u>	<u>59</u>	<u>60</u>	<u>60</u>
	TOTAL	269	271	272	274	275	277	280	280	282	283	284
Change in Coverage under the ACA, Updated for Supreme Court Decision	Medicaid and CHIP	*	1	7	9	10	10	11	11	11	11	11
	Employer ^e	1	1	-1	-2	-5	-5	-5	-6	-5	-4	-4
	Nongroup and Other ^c	1	*	-1	-1	-2	-2	-3	-2	-2	-3	-3
	Exchanges	0	0	9	14	23	25	26	26	25	25	25
	Uninsured ^d	-2	-2	-14	-20	-26	-28	-29	-29	-29	-30	-30
Uninsured Population Given the Supreme Court Decision												
Number of Uninsured Nonelderly People ^d		53	53	41	36	30	29	29	29	29	30	30
Insured Share of the Nonelderly Population ^a												
Including All Residents		80%	80%	85%	87%	89%	90%	90%	90%	90%	89%	89%
Excluding Unauthorized Immigrants		82%	82%	87%	89%	91%	92%	92%	92%	92%	92%	92%
<i>Memo: Exchange Enrollees and Subsidies</i>												
<i>Number with Unaffordable Offer from Employer^f</i>				*	*	1	1	1	1	1	1	1
<i>Number of Unsubsidized Exchange Enrollees</i>				1	2	4	4	4	4	4	5	5
<i>Average Exchange Subsidy per Subsidized Enrollee</i>				\$5,320	\$5,380	\$5,490	\$5,640	\$6,080	\$6,470	\$6,750	\$7,160	\$7,510

Sources: Congressional Budget Office and the staff of the Joint Committee on Taxation.

Notes: The Affordable Care Act (ACA) comprises the Patient Protection and Affordable Care Act (P.L. 111-148) and the health care provisions of the Health Care and Education Reconciliation Act of 2010 (P.L. 111-152). As used here, the term "ACA" also includes the effects of subsequent related changes to statute. This estimate incorporates the effects of the Supreme Court's opinion issued on June 28, 2012 (*National Federation of Independent Business v. Sebelius*, 132 S. Ct. 2566 (2012)).

CHIP = Children's Health Insurance Program; * = between 0.5 million and -0.5 million.

- Figures for the nonelderly population include only residents of the 50 states and the District of Columbia who are younger than 65.
- Figures reflect average annual enrollment; individuals reporting multiple sources of coverage are assigned a primary source. To illustrate the effects of the ACA, which is now current law, changes in coverage shown compared with coverage projections in the absence of that legislation, or "prior law."
- Other includes Medicare; the effects of the ACA are almost entirely on nongroup coverage.
- The count of uninsured people includes unauthorized immigrants as well as people who are eligible for, but not enrolled in, Medicaid.
- The change in employment-based coverage is the net result of increases in and losses of offers of health insurance from employers and changes in enrollment by workers and their families. For example, in 2019, an estimated 11 million people who would have had an offer of employment-based coverage under prior law will lose their offer under current law, and another 4 million people will have an offer of employment-based coverage but will enroll in health insurance from another source instead. These flows out of employment-based coverage will be partially offset by an estimated 9 million people who will newly enroll in employment-based coverage under the ACA.
- Workers who would have to pay more than a specified share of their income (9.5 percent in 2014) for employment-based coverage could receive subsidies via an exchange.

TABLE 4.

Estimate of the Budgetary Effects of the Insurance Coverage Provisions Contained in the Affordable Care Act, Updated for Supreme Court Decision

(Billions of dollars, by fiscal year)

EFFECTS ON THE FEDERAL DEFICIT ^{a,b}	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021	2022	11-Year Total, 2012-2022
Medicaid and CHIP Outlays ^c	-1	1	26	49	62	69	77	83	86	92	99	642
Exchange Subsidies and Related Spending ^d	2	4	25	61	97	119	129	137	141	148	155	1,017
Small Employer Tax Credits ^e	<u>1</u>	<u>2</u>	<u>3</u>	<u>4</u>	<u>2</u>	<u>1</u>	<u>2</u>	<u>2</u>	<u>2</u>	<u>2</u>	<u>2</u>	<u>23</u>
Gross Cost of Coverage Provisions	3	6	53	113	161	190	208	221	229	242	256	1,683
Penalty Payments by Uninsured Individuals	0	0	0	-3	-6	-7	-7	-7	-8	-9	-9	-55
Penalty Payments by Employers ^e	0	0	-4	-9	-11	-12	-14	-15	-16	-17	-18	-117
Excise Tax on High-Premium Insurance Plans ^e	0	0	0	0	0	0	-11	-18	-22	-27	-32	-111
Other Effects on Tax Revenues and Outlays ^f	<u>0</u>	<u>-1</u>	<u>-4</u>	<u>-7</u>	<u>-16</u>	<u>-25</u>	<u>-31</u>	<u>-36</u>	<u>-38</u>	<u>-37</u>	<u>-37</u>	<u>-231</u>
NET COST OF COVERAGE PROVISIONS	3	5	45	94	129	145	145	144	145	153	159	1,168

Sources: Congressional Budget Office and the staff of the Joint Committee on Taxation.

Notes: The Affordable Care Act (ACA) comprises the Patient Protection and Affordable Care Act (P.L. 111-148) and the health care provisions of the Health Care and Education Reconciliation Act of 2010 (P.L. 111-152). As used here, the term "ACA" also includes the effects of subsequent related changes to statute. This estimate incorporates the effects of the Supreme Court's opinion issued on June 28, 2012 (*National Federation of Independent Business v. Sebelius*, 132 S. Ct. 2566 (2012)).

Numbers may not add up to totals because of rounding.

CHIP = Children's Health Insurance Program.

- a. Does not include effects on the deficit of other provisions of the ACA not related to coverage, which in aggregate reduce deficits. It also does not include federal administrative costs that are subject to appropriation. CBO has previously estimated that the Internal Revenue Service will need to spend between \$5 billion and \$10 billion over 10 years to implement the ACA and that the Department of Health and Human Services and other federal agencies will have to spend at least \$5 billion to \$10 billion over that period. In addition, the ACA included explicit authorizations for spending on a variety of grant and other programs; that funding is also subject to future appropriation action.
- b. Positive numbers indicate increases in the deficit, and negative numbers indicate reductions in the deficit.
- c. Under current law, states have the flexibility to make programmatic and other budgetary changes to Medicaid and CHIP. CBO estimates that state spending on Medicaid and CHIP as a result of the coverage provisions of the Affordable Care Act in the 2012-2022 period would have increased by \$73 billion as a result of the law prior to the Supreme Court decision, and instead will rise by \$41 billion given that decision.
- d. Includes spending for high-risk pools, premium review activities, loans to co-op plans, grants to states for the establishment of exchanges, and the net budgetary effects of proposed collections and payments for risk adjustment and transitional reinsurance.
- e. The effects on the deficit of this provision include the associated effects on tax revenues of changes in taxable compensation.
- f. The effects are almost entirely on tax revenues. CBO estimates that outlays for Social Security benefits would increase by about \$7 billion over the 2012-2022 period, and that the coverage provisions would have negligible effects on outlays for other federal programs.